envolve
Benefit Options

UnitedHealthcare Community Plan STAR/STAR+PLUS/MMP Instructions for Obtaining Pre-Authorization for Ophthalmology Services

The following services require pre-authorization by Envolve Vision of Texas (Envolve Vision):

- New technologies or new applications of existing technologies.
- Any procedure code that is considered an unlisted procedure code as defined by the AMA Current Procedural Terminology (CPT) manual (CPT codes xxx99).
- 66982 is generally approved as 66984 and then considered for upgrade post-operatively upon request and with a copy of the operative report.

Please follow the instructions listed below when requesting a pre-authorization review:

- Ensure that the Envolve Vision Medical Pre-Authorization Request Form is **completely** filled out, including office and facility addresses, so your request can be processed in a timely manner.
- Provider signature is required on every request.
- Pre-authorization requests must include the codes for any additional procedures that will be performed during the surgical session.
- Providers must use participating UnitedHealthcare facilities and receive authorization for the facility and anesthesia from UnitedHealthcare. If an out-of-network facility is to be used, a facility authorization must be obtained directly from the health plan. Complete a facility notification form and fax to (866) 785-1649, or contact a representative at (888) 887-9003 and follow prompts. **Envolve Vision will not approve requests for services at out-of-network facilities until a facility authorization number is received.**
- Fax the completed form and any supporting clinical information to Envolve Vision at (877) 865-1077.
- After Envolve Vision has received the request it will be entered into the Utilization Management system and a Care Manager will review the information. If necessary, you may be contacted for additional information.
- **You will be notified within two business days upon completion of the review.**
    - If the requested service is approved, an authorization letter will be faxed to your office.
    - If the requested service results in a denial, the requesting Provider will be offered a peer to peer conference with an Envolve Vision Medical Director.
- **Written documentation for all decisions, whether approved or denied, will be issued within two business days.**

Pre-authorization requests using the online pre-authorization request:
Participating providers may utilize the Envolve Vision website to obtain pre-authorizations for cataract surgery (CPT 66984) at https://visionbenefits.envolvehealth.com/logon.aspx. For automatic approval of a pre-authorization request, the procedure must be performed at a participating UnitedHealthcare facility and the clinical information supporting the request must meet Envolve Vision guidelines for medical necessity (i.e., best-corrected visual acuity of 20/50 or worse). If a request for pre-authorization meets medical necessity guidelines, an approval number will be issued and the provider may print an authorization letter immediately. If a request for authorization does not meet the medical necessity guidelines, the request will pend for further review. **The provider should fax all supporting clinical information to Envolve Vision at (877) 865-1077**.

UnitedHealthCare Community Plan of Texas
Medical Pre-Authorization Request Form

________ **ROUTINE**

________ **URGENT ***

***A physician with knowledge of the patient's medical condition must determine it a case involving urgent care and that use of non-urgent timeframes could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function; or, based on the physician's opinion, the member would be subjected to severe pain. NOTE: Urgent requests MUST be accompanied by a physician's signature. The signature may appear either on this Pre-Authorization form, on the plan of care or medical record.**

Date____________ Office Contact_________________________ Phone________________________ Fax____________________________

Attending Physician ____NPI# ___________________________

TIN #___________________License #_______________________Medicaid #______________________ Medicare # ____________________

Patient Name (Last)______________________________(First)___________________(Middle)________________ DOB _________________

ID # ____HMO (Plan) ____________________________ Group # ______________________

Other Insurer (if any)____

Date of Admit _____________ Date of Service ______________ IP/OP (Circle One) Anticipated LOS_______________________________

Facility Name & Address ____

Facility Status: PAR NON-PAR Reason for Non-Par Request:____

Diagnosis (must be provided) **Procedure (must be provided)** **Circle (appropriate eye(s))**

ICD ____________ Description______________________CPT____________DESCRIPTION _________________________ RT LT 50

ICD ____________ Description______________________CPT____________DESCRIPTION_________________________ RT LT 50

ICD ____________ Description______________________CPT____________DESCRIPTION_________________________ RT LT 50

Medical Reason for Request ____

Attach additional pages if necessary

Patient's Chief Complaint____

Patient's BCVA OD___________________________________ OS ____________________________________

Target Refraction OD_______________________________________ OS____

A comprehensive ophthalmic evaluation, including manifest refraction documenting the medical necessity for cataract surgery must be done no longer than three months prior to surgery.

Signature of Attending Physician: ____ Date:________________________

Office Address: ____

PRE CERTIFICATION/AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. COVERED SERVICES ARE BASED ON MEMBER ELIGIBILITY AND BENEFIT LIMITATIONS AT THE TIME SERVICE(S) ARE RENDERED.
PLEASE FAX YOUR REQUEST TO: (877) 865-1077 OR MAIL TO:
ENVOLVE VISION OF TEXAS, INC., ATTN: UTILIZATION MANAGEMENT, PO BOX 7548, ROCKY MOUNT, NC 27804

If denied, please refer to your Provider Manual or call (800) 465-6972 to be informed of your appeal rights.

The information contained in this transmission is intended only for the use of the individual or entity to whom it is addressed and may contain information that is confidential and exempt from disclosure under applicable law*. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in *error, please notify us immediately by telephone and return the original message to us at PO Box 7548, Rocky Mount, NC 27804, via the United States Postal Service. We apologize for any inconvenience this may have caused you. Thank you.